REVIEWED BY R.N. ____________________ **DATE** _____________

FONTANA UNIFIED SCHOOL DISTRICT
COMPREHENSIVE HEALTH SERVICES

REQUEST FOR SPECIALIZED HEALTH CARE SERVICE

We (I), the undersigned, who are the parents/guardians of ______________________________________
(Name of Student)

_____________________, request that the following specialized physical health care services
(Birthdate)

be administered to our child in accordance with Education Code Section 49423.5 and California

Administrative Code, Title 5, Sections 3112(s) and/or 3797:

____

____

We understand that the school administrator will appoint a qualified designated person(s) who, in accordance

with Education Code Section 49423.5, will be performing the above mentioned health care service.

It is our understanding that in performing this service, the designated person(s) will be using a standardized

procedure that has been approved by our physician:

____ ____________________
Physician's Name Phone

____ ____________________
Address City/Zip

We will notify the school immediately if the health status of ____________________________________
(Name of Student)

changes, if we change physician, or if the procedure is changed or cancelled.

We understand that, whenever possible, the specialized physical health care service should be provided

before or after school hours.

____
Signature of Parent/Guardian Date

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Updated 07/2012

REVIEWED BY R.N. ______________________________ DATE ______________

DISTRITO ESCOLAR UNIFICADO DE FONTANA
SERVICIOS DE SALUBRIDAD

SOLICITUD DE SERVICIOS DE SALUD ESPECIALIZADOS

Nosotros (Yo), los abajo firmantes, padres/tutores de:______________________________
(Nombre del Estudiante)

____________________, solicitamos que los siguientes servicios de salud fisica
(Dia Del Nacimiento)

especializados se otorgen a nuestro hijo/a menor, de acuerdo a la Seccion 49423.5 del Codigo de Educacion y el Codigo Administrativo de California. Titulo 5, Secciones 3112(s) y/o 3797.

____

____

Tenemos entendido que el director de la escuela designara a la(s) persona(s) calificada(s) quien(es), de acuerdo con la seccion 49423.5 del Codigo de Educacion, desarrollara(n) los servicios de salud arriba mencionados. Tenemos entendido que al realizar tales servicios, la(s) persona(s) designada(s) usara(n) procedimientos comunes aprobados por nuestro medico.

______________________________ ____________________
Nombre del Medico Telefono

______________________________ ____________________
Direccion Ciudad/Postal

Avisaremos inmediatamente a la escuela si la condicion fisica de ______________________________
(Nomber De Estudiante)
cambiara, si cambiamos de medico o si el tratamiento cambiara o se cancelara.

Tenemos entendido que, cuando sea posible, los servicios de salud especializados se daran antes o despues de horas de clase.

______________________________ ____________________
Firma del Padre/Tutor Fecha

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Updated 07/2012